Agility
Gap & CoPay

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AGILITY *GAP* & *COPAY* APPLICATION

Requested start date: D D M M Y Y Y Y

Please attach the following documentation to this application form:

Copy of principal insured's and dependants' ID / Passport ☐

Copy of current medical scheme membership certificate ☐

Cover will commence after the 1st successful debit order. Should this form be received after the 21st of the month, we reserve the right to change the inception date to the 1st of the following month. The activation of application forms are subject to the underwriting process of the insurer and may result in the activation of membership after the indicated/requested activation date. This application form must be received at the insurer within 1 month following the date on which it was signed. Failure to do so will result in this application being null and void. Incomplete application forms will not be accepted.

A. PRINCIPAL MEMBER PARTICULARS

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any accepted products, the information provided in this section will form part of the contract.

Surname		Title	
First name(s) *(in full)*		Initials	
ID / Passport no.	Date of birth: D D M M Y Y Y Y	Gender	M F

B. DETAILS OF DEPENDANTS

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any accepted products, the information provided in this section will form part of the contract. Dependants are defined as children or other members of immediate family in respect of whom the member is liable for care and support.

	Spouse / Partner / Dependant **1** ☐	Dependant **2** ☐
Dependant type		
Surname		
First name(s) *(in full)*		
Initials	Title / Gender M F	Title / Gender M F
ID / Passport no.		
Date of birth	D D M M Y Y Y Y Age	D D M M Y Y Y Y Age
Relationship to member		
	Disabled ☐ Full-time student ☐	Disabled ☐ Full-time student ☐

	Dependant **3** ☐	Dependant **4** ☐
Dependant type		
Surname		
First name(s) *(in full)*		
Initials	Title / Gender M F	Title / Gender M F
ID / Passport no.		
Date of birth	D D M M Y Y Y Y Age	D D M M Y Y Y Y Age
Relationship to member		
	Disabled ☐ Full-time student ☐	Disabled ☐ Full-time student ☐

Where relevant, please attach:

- Proof of full-time student status from a registered institution for the applicable academic year.
- Handicapped children: Physician report to confirm disability.
- Documentary proof for immediate family who are financially dependent on the principal member.

Should you be unable to provide copies of the aforementioned documents:

I, the principal insured, hereby declare that all reasonable efforts have been made to obtain evidence of my depend[...] ...ave been unsuccessful. Should proof not be submitted within three (3) months membership may be cancelled.

SIGNATURE

Signature of applicant

Name of appilcant

D

Signa[...]

C. CONTACT DETAILS OF PRINCIPAL MEMBER

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any accepted products, the information provided in this section will form part of the contract.

Physical address

Code

Postal address

Code

E-mail address

Tel (H) Tel (W) Mobile

Please select your preferred method of communication to receive important information and related product content: SMS E-mail

D. PRODUCT SELECTION

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any selected products, the information provided in this section will form part of the contract.

Gap 200 *Gap 350* *Gap 500* *CoPay*

Combined 200 *Combined 350* *Combined 500* **Agility** *Ultra*

Dental & Optom VAP

Requested date of commencement of membership D D M M Y Y Y Y NOTE: SUBJECT TO UNDERWRITING

SIGNATURE

Signature of applicant

Name of applicant

D D M M Y Y Y Y

Signature date

E. MEDICAL QUESTIONS

The medical information contained in this section will be used to assess risk and will form part of any and all insurance contracts resulting from this application and is hereby specifically incorporated into any and all such contracts.

- All questions must be answered with a NO or YES. Incomplete, inaccurate or withheld information may result in the termination of your membership.
- If you have had medical scheme cover within the last 3 months, and you answered YES to any of these questions, please complete all the additional sections in the addendum as indicated.
- If you have not had medical scheme cover within the last 3 months, all the sections in the addendum must also be completed.

Has ANY person indicated on the application form:

Question		
1. Taken, or expect to take, chronic medication on an ongoing basis?	NO	YES, complete Addendum **3,** pg 4
2. Ever had, or expects (in the next 12 months) to have, any procedure or be admitted to hospital?	NO	YES, complete Addendum **2,** pg 4
3. Ever suffered from any physical or mental impairment or other disability?	NO	YES, complete Addendum **1,** pg 3
4. Ever abused illegal substances or alcohol?	NO	YES
5. Ever suffered from any other specific or related condition not mentioned above for which advice, diagnosis, care or treatment was recommended or received, or presented any symptoms which could potentially or reasonably be expected to result in a claim in the next 12 months?	NO	YES, complete Addendum **1,** pg 3

Please note that any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Insurer null and void. In addition, any payment made due to such actions will be recovered from the member by the Insurer.

Please note that this questionnaire does not constitute an application for chronic medication or any other benefit.

F. SPECIFIC HEALTH QUESTIONS

ADDENDUM 1

State whether you or any of your dependants have ever suffered from, been treated for, or are currently receiving treatment, or expect to receive treatment for any of the following illnesses, **including but not limited to:**

1.	Blood disorders, e.g. anaemia, bleeding disorders, haemophilia, leukaemia, clotting disorders.	NO	YES
2.	Cancer, growths, abscess or tumours of any kind, whether benign or malignant.	NO	YES
3.	Cardiovascular (heart and blood vessels) disorders e.g. congenital heart conditions, chest pain, coronary artery disease / ischaemic heart disease, high blood pressure, valvular disease, arrhythmias, varicose veins, blood clots, poor circulation or arterial disease, rheumatic fever, shortness of breath, palpitations, angina, deep vein thrombosis, pulmonary embolism, atherosclerosis, lymphatic disease	NO	YES
4.	Ear, nose and throat disorders e.g. hearing / speech impairment, ear infections, sinus problems, nasal / throat surgery, ear discharge, hoarseness, mouth disorders, tonsils, adenoids, grommets, previous nasal injuries, upper airway infections, cleft lip / palate, epistaxis, hay fever / rhinitis, blocked nose.	NO	YES
5.	Endocrine disorders e.g. high cholesterol, diabetes, thyroid abnormalities, sugar in urine, nutritional disorders, metabolic syndrome, hypo / hyperglycaemic coma, insulin resistance.	NO	YES
6.	Eye disorders e.g. glaucoma, blindness, eye surgery, retinitis pigmentosa, cataracts, lens implants, infections, refractive and laser surgery, short or far sightedness, pterygium.	NO	YES
7.	Gastro-intestinal disorders e.g. recurrent indigestion, heartburn, reflux, ulcers, bowel disorders, gallbladder disorders, liver disorders, pancreas disorders, hiatus hernia, piles, anal fissures, rectal bleeding, ulcerative colitis, spleen disorders, Crohn's disease or have you or any dependants ever had a gastroscopy or colonoscopy?	NO	YES
8a.	Gynaecological and obstetrical disorders e.g. ectopic pregnancy, caesarean section, fibroids, endometriosis, menstrual irregularities, abnormal pap smear, receiving hormone treatment, vaginal bleeding, laparoscopic surgery, dilatation and curettage, miscarriages, pregnancy related problems, cysts, infertility, breast disorders.	NO	YES
8b.	Pregnancy: Expected date of delivery D D M M Y Y Y Y	NO	YES
9.	Male genitourinary system e.g. testes, prostate, abnormalities of the penis, scrotum, reproductive system.	NO	YES
10.	Musculoskeletal disorders e.g. osteoarthritis, rheumatoid arthritis, back problems, gout, osteoporosis, all joint problems e.g. knee, shoulder, bones, limbs, spine, fractures, carpal tunnel syndrome, bunion, spondylosis, hernia, kyphosis, scoliosis.	NO	YES
11.	Neurological disorders e.g. epilepsy, muscular weakness, stroke, brain or spinal cord disorders, chronic fatigue, headache, migraine, polio, paralysis, Guillain-Barre, meningitis, Parkinson's disease, Alzheimer's disease, dementia, chronic neurologic disorders.	NO	YES
12.	Psychological disorders e.g. insomnia, anxiety, depression, stress, panic attacks, alcohol or drug dependency, attention deficit disorder, post-traumatic stress, schizophrenia, bipolar disorders, mood swings, attempted suicide, anorexia nervosa, bulimia.	NO	YES
13.	Renal (kidney) disorders e.g. blood in the urine, urinary tract stones, recurrent infections, kidney failure, bladder problems, dialysis, Addison's disease, nephritis.	NO	YES
14.	Respiratory disorders e.g. asthma, allergic rhinitis, chronic bronchitis, emphysema or cigarette smoking related disorders, tuberculosis, persistent cough, allergies, chronic obstructive pulmonary disease, pneumoconiosis.	NO	YES
15.	Skin disorders e.g. eczema, psoriasis, melanoma, skin cancer, burns, acne, scars, keloids, growths, warts, ingrown toenails.	NO	YES
16.	State whether you or any of your dependants have received medical advice or treatment for any infectious or tropical disease e.g. gonorrhoea, genital herpes, syphilis, TB, hepatitis, bilharzia, malaria, cholera.	NO	YES
17.	Do you or any of your dependants have any birth defects or hereditary disorders?	NO	YES
18.	Have you or any of your dependants ever sought counselling or treatment for HIV or AIDS-related infections or ever tested positive for HIV or AIDS?	NO	YES
19.	Have you or any of your dependants ever been diagnosed and / or treated for an immune system problem?	NO	YES
20.	Previous injuries and trauma including sports injuries?	NO	YES
21.	Do you or any of your dependants have incomplete dental treatment plans, dental implants, orthodontic treatment, dentures or wisdom teeth problems?	NO	YES

If YES was answered to any of the questions above, please supply full details below. If the space below is insufficient, please use additional paper.

QUESTION	APPLICANT/ DEPENDANT	DATE	DISORDER	TREATMENT	CONSULTING DC	CURRENT CONDITION

PROCEDURES AND HOSPITAL ADMISSIONS

ADDENDUM 2

Please supply details of all procedure(s) and all hospital admissions that you, or any of your dependants, have undergone in the past, and/or details of all planned procedure(s) and all hospital admissions that you, or any of your dependants, expect to undergo in the future.

APPLICANT/DEPENDANT	PROCEDURE/HOSPITAL ADMISSION	DATE	REASON	DOCTOR	CURRENT CONDITION

CHRONIC CONDITIONS

ADDENDUM 3

1. Please supply details of any chronic medication (prescribed medicines used continuously for more than 3 months) currently prescribed for you or any of your dependants.
2. Should you or any of your dependants expect chronic medication to be prescribed in the next 12 months, please supply details below.

APPLICANT/DEPENDANT	PRESCRIBED MEDICATION	MEDICAL CONDITION	DATE STARTED/TO BE STARTED

G. HEIGHT AND WEIGHT

Principal member	Initials		Height		cm	Weight		kg
Spouse/Partner/ Dependant 1	Initials		Height		cm	Weight		kg
Dependant 2	Initials		Height		cm	Weight		kg
Dependant 3	Initials		Height		cm	Weight		kg
Dependant 4	Initials		Height		cm	Weight		kg

Please note that any misrepresentation or non-disclosure of medical material or factual information will render all benefits granted by the Insurer null and void. In addition, any payment made due to such actions will be recovered from the insured by the Insurer.

SIGNATURE

Signature of applicant

Name of applicant

M Y Y Y Y

Agility Insurance Administrators (PTY) Ltd is an Authorised Financial Services Provider (FSP44024). Agility Insure is a division of Agility Insurance Administrators (PTY) Ltd. Products are underwritten by GENRIC Insurance Company Ltd (FSP 43638). GENRIC Insurance Company Ltd is an Authorised Financial Services Provider.

H. BANKING DETAILS AND PAYMENT AUTHORISATION

The information supplied in this section is applicable to all product classes applied for hereunder. On acceptance of the application for any selected products, the information provided in this section will form part of the contract.

Bank details to use for debit order collections of any of the selected products:
Please note: Contributions are due on date selected. I, the undersigned, hereby authorise GENRIC Insurance Company Ltd or its nominee to withdraw amounts against my bank account (as indicated below) on the date selected, in accordance with and as specified by the insurance. GENRIC Insurance Company Ltd, its nominee or Agility Insurance Administrators (Pty) Ltd may not unilaterally terminate any current debit order signed by you (the policyholder) without having informed you, in writing, of the intention to terminate the debit order at least 30 days before the effective date of such envisaged termination.

Name of bank | Branch name

Account type: Cheque / Transmission / Savings | Branch code

Name of account holder

Account no.

Agility *Gap* & *CoPay* contributions will only be debited on the 1st of every month.

Bank details to use for claim refunds

Name of bank | Branch name

Account type: Cheque / Transmission / Savings | Branch code

Account holder

Account no.

GENRIC Insurance Company Ltd claims will be reimbursed at scheme rate, unless otherwise indicated. All other claims will be reimbursed as per the policy document. GENRIC Insurance Company Ltd is hereby authorised to draw against the above bank account the amount due in terms of this contract, wherever it may be conducted. Similarly, I authorise my bank to debit my account with amounts drawn against it by the Insurer.

I understand that the withdrawals hereby authorised will be processed by computer through a debit order system and I also understand that the details of each withdrawal will be printed on my bank statement. I agree to pay any bank charges relating to this instruction.

The authority may be cancelled by myself giving GENRIC Insurance Company Ltd one calendar months' notice in writing by completing a cancellation form, but I understand that I shall not be entitled to any refund of amounts which the insurer has withdrawn while this authority was in force if such amounts were legally owing to the insurer. Receipt of this instruction by GENRIC Insurance Company Ltd shall be regarded as receipt thereof by my bank.

I further agree to advise GENRIC Insurance Company Ltd in writing of any changes which may occur.

SIGNATURE | | D D M M Y Y Y Y
Signature of bank account holder | Name of bank account holder | Signature date

Note: If the bank account holder is not the principal member, the Insurer requires an authorisation letter and a copy of ID / Passport from the bank account holder to be attached to this application form.

I. INTERMEDIARY DETAILS

Name of brokerage | Date D D M M Y Y Y Y

Brokerage tel

Brokerage e-mail address

Name and surname of broker

Broker tel | Broker cell

Broker e-mail address

Name and surname of Broker Consultant

Broker Consultant tel | Broker Consultant cell

Broker Consultant e-mail address

AIA broker code

SIGNATURE | SIGNATURE
Signature of applicant | Signature of broker

Broker Consultants and signatories
will not be accepted. Applications M
the broker.

Sections only to be completed if principal member has selected to purchase the product:

J. AGILITY *GAP / COPAY* OR *COMBINED* DECLARATION BY PRINCIPAL MEMBER

I, the undersigned, hereby declare that:

1. To the best of my knowledge, the information provided in connection with this application, whether it be in my own handwriting or not, is true and that I have not withheld any material facts which are known to me. A material fact is defined as a fact that is likely to impact the assessment of this application by Agility Insurance Administrators (Pty) Ltd.

2. I understand that any relevant material fact omitted from this application form may lead to Agility Insurance Administrators (Pty) Ltd not meeting claims, should the omitted fact have been of such importance that the risk may not have been accepted in the first instance, in terms of the policy. This may lead to cancellation of this policy or rejection of claims without refund of premiums where applicable.

3. I understand that this is an accident and health policy with stated benefits in terms of the Short Term Insurance Act no 53 of 1998, and not a medical scheme product.

4. I acknowledge that the sharing of claims information and underwriting (including credit information) by the insurers is essential to enable the insurance industry to underwrite policies and assess risk fairly and reduce the incidence of fraudulent claims, in the public interest and with a view to limiting premiums. I hereby waive any rights to privacy in any claims information supplied by me or on my behalf in respect of any insurance claim made or lodged by me and I consent to such information being disclosed to any other insurance company or its agent. I also waive any rights of privacy and consent to the disclosure of any information relevant to the claims concerning me or any person I represent. I further acknowledge that the information provided by me may be verified against other legitimate sources or databases.

5. I specifically consent to Agility Insurance Administrators (Pty) Ltd contacting my current medical scheme and/or medical practitioner to verify any medical details as provided in my application form. I further consent to information being disclosed to Agility Insurance Administrators (Pty) Ltd for purposes of verifying the disclosure as provided on my application form.

Signed at ________________________ on this ___________________ day of __________ / __________

SIGNATURE

Signature of applicant

SIGNATURE

Signature of spouse if married in community of property

____

Name of applicant

____

Name of spouse if married in community of property

K. IMPORTANT INFORMATION

I, the undersigned, hereby confirm that:

1. A family means two adults and three children under the age of 18 years. Concessions can be made for children who are financially dependent on their parents (21), or full-time students (25). A letter from me should be sent to Agility Insurance Administrators (Pty) Ltd to prove that the child is financially dependent, and a letter from a registered and recognised tertiary education institution to prove full-time student status.

2. Adult dependants, such as the main member's mother or father, will need to be placed on a separate policy.

3. I will ensure that **full** details are provided for any medical condition questions answered YES.

4. Application forms will be underwritten and conditions may be excluded for longer than 12 months, or permanently. A Terms of Acceptance letter will be sent to me to confirm this.

5. The onus lies on me to make sure that premiums are paid on a monthly basis.

I hereby confirm that cognisance has been taken of the contents of the abovementioned conditions, which I understand and that the information is true and correct.

SIGNATURE

Signature of applicant

____

Name of applicant

D	D	M	M	Y	Y	Y	Y

Signature date

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